WITHIN CORPORATE LIMITS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02600

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 162 Polk Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant Ammons

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1940

8. AGE: Years: | Months: 4 months | Days: fetus | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: David Ammons
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Blanch Jones
15. Birthplace: Maryland

16. Informant: David Ammons
Address: 162 Polk Street, Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof March 17, 1940 (month) (day) (year)
Cemetery or crematory: Louis Stein, Inc Funeral Home
Location: Cumberland Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 19, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 17, 1940, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 17, 1940 to Mar 17, 1940, and that I last saw him alive on March 17, 1940.

Immediate cause of death	DURATION
Intrauterine Asphyxia	3-17-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur T. Jones M. D.
M. D. or other
Address: 402 Liberty St. Date signed: 3-18-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

02601

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 301 Wallace Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 301 Wallace Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Susan Banks

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: A. R. D. Banks
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1860 ??

8. AGE: Years	Months	Days	If less than one day
About 79			hrs. min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Korns
13. Birthplace: Unk.

MOTHER
14. Maiden name: "
15. Birthplace:

16. Informant: A. R. D. Banks
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 17, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 17 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

Dr. Langston

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1939 to March 15 1940, and that I last saw h[illegible] alive on March 15th 1940

Immediate cause of death	DURATION
Mitral Regurgitation	4 Mo.
Due to	
Due to	
Other conditions: Bronchitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): no
Means of injury: Injured at work?

23. SIGNATURE: J. I. Langston M. D. or other
Address: 54 N. mech. st Date signed: 3-16-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

02602

(97)

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Allegany County Home St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Edward A. Barnett — If U. S. Veteran, specify WAR ____

(a) Residence: No. 211 Bedford St., Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Wurtzbacken

6. DATE OF BIRTH (month, day, and year) Feb. 19, 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	90	0	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Leather Inspector

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Retired

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Howard Rabold

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown Unknown

16. BIRTHPLACE (city or town) (State or country) ____

17. INFORMANT John Edward Barnett

(Address) Cumberland, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place St. Luke Cem. Cumberland, Md. Date Mar. 9, 1940

19. UNDERTAKER Louis Stein, Inc.

(Address) Cumberland, Md.

20. FILED Mar. 7, 1940 J. P. Franklin, M.A. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 3 (Month) — 7 (Day) — 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 2-9-, 1939, to 3-7-, 1940

I last saw him alive on 3-5-, 1940; death is said to have occurred on the date stated above, at 9 a m

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arterio sclerosis ?	

Other Contributary Causes of Importance:

Name of operation None Date of ____

What test confirmed diagnosis? Phy. Exam. Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Neture of injury ____

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify ____

(Signed) W. F. Watson M. D.

(Address) Cumberland, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
APR 8 1930
BUREAU OF

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

02603

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1472)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 6 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Greens Addition
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Helen MARGUERITE BARTON

3. (b) Social Security Number 220-10-7324

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 1 1921

8. AGE: Years 18 Months 11 Days 21 If less than one day hrs. min.

9. Birthplace MARYLAND Westernport
(Town, county, and state)

10. Usual occupation CELANESE Corp. of America

11. Industry or business Employee

FATHER
12. Name HERBERT BARTON
13. Birthplace ~~MARYLAND~~ Winchester Va.

MOTHER
14. Maiden name Alice Miller
15. Birthplace Elk Garden W. Va.

16. Informant Herbert Barton
Address Westernport, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar. 25, 1940 (month) (day) (year)

Cemetery or crematory Philos.

Location Westernport Md.

18. Funeral director David S. Boal
Address Westernport Md.

19 Mar 23, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 22 19 6:55 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1940, to March 22 1940, and that I last saw h[illegible] alive on 19

Immediate cause of death Puerperal sepsis

DURATION 9 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Cafe of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. McWilson [signature] M. D. or other

Address Cumberland Md Date signed 3-22-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-P)

02604

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 403 Arch Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 403 Arch Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Bennett Bedinger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife: Elizabeth Dougherty
G(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 18, 1857

8. AGE: Years	Months	Days	If less than one day
82	3	13	hrs. min.

9. Birthplace: Hanging Rock, W. Va. (Town, county, and state)
10. Usual occupation: Merchant, retired
11. Industry or business: Grocery

FATHER
12. Name: James B. Bedinger
13. Birthplace: Unknown

MOTHER
14. Maiden name: Catherine ???
15. Birthplace: Unknown

16. Informant: Joseph H. Bedinger
Address: City

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Mar. 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Eliason

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1940, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1939, to March 2, 1940, and that I last saw h[illegible] alive on March 2, 1940.

Immediate cause of death	DURATION
Chronic Nephritis	1939
Due to Chronic myocarditis	1939
Due to arteriosclerosis	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. W. Eliason M.D.
M. D. or other
Address: 126 Union St. Cumberland Md. Date signed: 3/4/40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMIT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02605

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 14 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 185 Bowery St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Aden Lee Bender

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 16 - 1939

8. AGE: Years: 1 | Months: 2 | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Frostburg Allegany Co. Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Geo. Bender
13. Birthplace: Eckhart Md

MOTHER
14. Maiden name: Bertie McCormick
15. Birthplace: Lonaconing Md.

16. Informant: Geo. Bender
Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 17 - 1940 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetary
Location: Eckhart Md.

18. Funeral director: J. J. Hurst
Address: Frostburg Md.

19. 3-17th-1940 (Date rec'd by registrar) Mrs. A. R. Walker, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1940, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1940, to March 14 1940, and that I last saw him alive on March 14 1940.

	DURATION
Immediate cause of death: Bronchial Pneumonia	1 day.
Due to: Streptococcic sore throat	10 days.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: H. C. Diehl, M. D. or other
Address: Frostburg, Md Date signed 3/16/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-C

02606

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:
County Allegany
City or town Barton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Brooks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Isabelle Moose Brooks

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26 1859

8. AGE: Years	Months	Days	If less than one day
80	10	26	hrs. min.

9. Birthplace Barton, Md.
(Town, county, and state)
10. Usual occupation Miner
11. Industry or business Coal Mine
FATHER 12. Name Solomon Brooks
13. Birthplace Germany
MOTHER 14. Maiden name Mary Bloadwater
15. Birthplace Barton, Md.
16. Informant Edward Brooks
Address Pittsburg Penna.
17. Burial Date thereof Mar. 22 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Morrison Cemetery
Location Reynolds Md. near Barton Md.
18. Funeral director David S. Boal
Address Barton, Md.
19. March 20 1940 S. A. Boucher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 1940, at 1:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940 to March 19 1940, and that I last saw h alive on March 2 1940.

Immediate cause of death	DURATION
cancer of testicles	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other
Address Lonaconing, Md. Date signed Mch 22 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

02607

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegheny

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 206 Green St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegheny

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 206 Green St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Ellen Byer

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Byer

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 25 1857

8. AGE: Years: 82 Months: 10 Days: 0 If less than one day ____ hrs. ____ min.

9. Birthplace: West Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Deck
13. Birthplace: West Va

MOTHER
14. Maiden name: Daisy Smythe
15. Birthplace: W. Va

16. Informant: J. Walter Byer
Address: 206 Green St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 29, 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport Md

18. Funeral director: Virgil L. Lempereur
Address: 202 Green St

19. Mar. 27 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th 1940, at 9 45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20th 1940, to March 26 1940, and that I last saw her alive on March 25 1940.

Immediate cause of death: Arterio Sclerosis

Due to: Thrombo Angiitis angiitis

Due to: Obliterans both feet.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. C. Bowen M.D. M. D. or other

Address: Cumberland Md Date signed: 3.26.40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02608

Reg. Dist. No. 4c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 months

Stay in this community (yrs., or mos., or days) 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Lisbon Ind. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Laurie Cage

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

8 (b) Name of husband or wife Single

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1939

8. AGE:

Years	Months	Days	If less than one day
	4	2	hrs. min.

9. Birthplace Lisbon Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Edward Cage

13. Birthplace Cumberland

MOTHER 14. Maiden name Leoda Brooks

15. Birthplace Cumberland

16. Informant Leoda Cage

Address Lisbon Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 20, 1940 (month) (day) (year)

Cemetery or crematory Davis Memorial Cem.

Location The Highway Cumberland

18. Funeral director Jesse Hafer

Address Cumberland, Md.

19. 3-19-40 (Date rec'd by registrar) Jos. R. Franklin M.D. Registrar

Walter Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1940, at 10a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1940, to Mar 19 1940

and that I last saw her alive on Mar 19 1940

Immediate cause of death	DURATION
Gastro-enteritis (non-infective)	
Due to Prematurity, (twin)	
Due to	
Other conditions Marasmus.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter B. Johnson M. D., or other

Address Cumberland, Md Date signed 3-19-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

02609

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 327 Williams Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 327 Williams Street (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ruth Verna Campbell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: John F. Campbell
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1894

8. AGE: Years	Months	Days	If less than one day
45	11	25	hrs. min.

9. Birthplace: Davis, West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Paul Rohm
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Myrtle Snyder
15. Birthplace: Pennsylvania

16. Informant: John F. Campbell
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 27, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 24 1940, at 9:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1939, to Mar 24 1940, and that I last saw her alive on Mar 23 1940

Immediate cause of death	DURATION
Malignancy of Uterus with Metastasis to bladder vagina and abdominal Viscera.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Knight Reynolds M.D.
M. D., or other
Address: Cumberland Md Date signed: Mar 27/40

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83-a

02610

Reg. Diat. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Loantown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Loantown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bertha Ellen Capel

3. (b) Social Security Number None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edw. Capel

6(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Oct 15 - 1880

8. AGE: Years: 59 Months: 4 Days: 21 If less than one day: hrs. min.

9. Birthplace: Loantown - alleg - md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: John Ross

13. Birthplace: Friendsville, md.

MOTHER 14. Maiden name: Susan Loar

15. Birthplace: Loantown, md.

16. Informant: Edward Capel

Address: Loantown, md.

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Mar 9 - 1940 (month) (day) (year)

Cemetery: Vale Summit

Location: Vale Summit, md.

18. Funeral director: J. J. Dumpt

Address: Frostburg md.

19. Mar 9 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 1940, at ?? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1940 to Mar 6 1940, and that I last saw h-- alive on Feb 24 1940

	DURATION
Immediate cause of death: Probably Cerebral Hemorrhage - Found dead sitting in chair about 11:15 AM	
Due to	
Due to: Had been treated by me for what seemed to be neurasthenia	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr MD M. D. or other

Address Frostburg Md Date signed Mar 8 40

RECEIVED
APR 2 1940
BUREAU V. S.

02611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Jackson Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Jackson, Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Carrie E. Clise

3. (b) Social Security Number ✓

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife ✓

✓ 6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1880

8. AGE: Years 59 Months 6 Days 0 If less than one day ___ hrs. ___ min.

9. Birthplace Borden Shaft, Md
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER
12. Name Peter Clise
13. Birthplace Clarysville, Md

MOTHER
14. Maiden name Louise Poland
15. Birthplace Maryland

16. Informant Mrs. Martin

Address Youngstown, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 11 1940 (month) (day) (year)

Cemetery or crematory Old Coney Cemetery

Location Lonaconing, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Mar. 11th 1940 (Date rec'd by registrar) A. E. Pontyk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1939, to March 1940, and that I last saw him alive on March 9, 1940

Immediate cause of death Cardiac Dilatation
Auricular Fibrillation

DURATION
2 days
6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Friedman M.D. M. D. or other

Address Lonaconing Date signed March 14 1940

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02612

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital Decatur St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna. County Bedford

City or town Hyndman Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Clutes

3. (b) Social Security Number None

4. Sex: M | 5. Color or race: W | 6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Stillborn Mar. 24, 1940

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland, Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Clyde W. Clutes

13. Birthplace Hyndman Pa.

MOTHER 14. Maiden name Eva J. Sides

15. Birthplace Hyndman Pa

16. Informant Clyde W. Clutes

Address Hyndman Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/40 (month) (day) (year)

Cemetery or ~~crematory~~ Hyndman

Location Hyndman Pa

18. Funeral director Harvey A. Zeigler

Address Hyndman Pa.

19 Mar. 24, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20

20. DATE OF DEATH 3/24 1940, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24 1940, to 3/24 1940, and that I last saw him alive on 3/24/40 1940

Immediate cause of death: Stillborn — DURATION: 1 hr.

Due to (Impaired fetal blood supply)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D.
M. D. or other

Address Hyndman Pa. Date signed 3/24/40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

02613

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days) 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Hyndman Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Clites

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1940

8. AGE:

Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Clyde William Clites

13. Birthplace Maryland

MOTHER

14. Maiden name Iva Pearl Lides

15. Birthplace Hyndman, Penna.

16. Informant Clyde Clites.

Address Hyndman, Pa.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 3/28/40 (month) (day) (year)

Cemetery or crematory Hyndman

Location Hyndman Pa

18. Funeral director Harvey H. Zeigler

Address Hyndman Pa

19. Mar. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1940, to March 27th 1940, and that I last saw h/M alive on March 27th 1940.

Immediate cause of death	DURATION
Pulmonary Atelectasis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper MD (M. D. or other)

Address Hyndman Pa Date signed 3/27/40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

02614

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 109 So. Smallwood St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 109 So. Smallwood
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Mary Cronin

3. (b) Social Security Number None

4. Sex F. | 5. Color or race W. | 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Late Patrick Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 - 1856

8. AGE: Years 84 | Months 2 | Days 1 | If less than one day hrs. min.

9. Birthplace Ft Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Keating
13. Birthplace Ireland

MOTHER
14. Maiden name Julia Highland
15. Birthplace Ireland

16. Informant Mrs Kathryn Hawkins
Address Cumberland Md

17. Burial Date thereof 3/15/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter & Paul's

Location Cumberland Md

18. Funeral director V. L. Lemperen
Address Cumberland, Md.

19. Mar. 15 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March. 17 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 1939, to Mch. 17, 1940, and that I last saw her alive on Mch. 21 - 1940.

Immediate cause of death Myocarditis. | 4 DURATION

Due to Chronic myocarditis.
Duration: One year. C.W.S.B.

Due to

Other conditions Senility.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. T. O. Snyder
M. D. or other
Address Cumberland Md. Date signed 3-14-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02615

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 week

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corriganville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mr. Frank Delbrook

3. (b) Social Security Number: 705-05-4522

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Bertha Gertude Witt

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/20/1883

8. AGE: Years	Months	Days	If less than one day
56	8	6	hrs. min.

9. Birthplace: Wellersburg Pa.
(Town, county, and state)

10. Usual occupation: Boiler maker

11. Industry or business

FATHER
12. Name: Henry Delbrook
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Catherine Everline
15. Birthplace: Pennsylvania

16. Informant: Calvin Delbrook
Address: Corriganville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 29,40 (month) (day) (year)

Cemetery or crematory: Wellersburg

Location: Wellersburg Pa.

18. Funeral director: Harvey Hyndman Hyndman Pa.

Address: Hyndman Pa.

19. Mar. 28 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29, 1940, to March 26, 1940, and that I last saw him alive on March 26, 1940.

Immediate cause of death	DURATION
Encephalitis	9 days
Due to Influenza	5 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None

Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

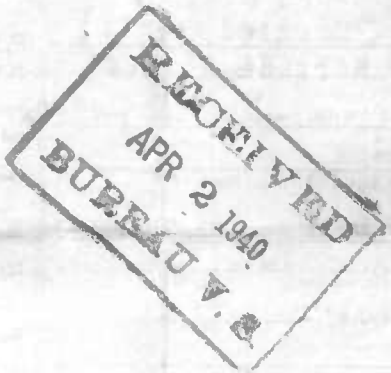
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland, Md. Date signed: 3:28:40


RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 940 Reg. Dist. No. 8

CERTIFICATE OF DEATH

03610

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) 6 years

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town National (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** James Isaac Devault

3 (b) If veteran, name war —

3 (c) Social Security No. 214-01-3664

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Leah Robinson Devault

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb. 18 1875

8. AGE: Years 65 | Months 1 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Coal Mines

FATHER
12. Name Daniel Devault
13. Birthplace

MOTHER
14. Maiden Name Susanna Noel
15. Birthplace

16 (a) Informant Mrs. Chas. Devault
(b) Address National, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27 1940 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md.

18 (a) Funeral director Wm. Eichhorn
(b) Address Lonaconing, Md.

19 (a) March 26 1940 (Date rec'd by registrar) (b) E. Dan Tyler Registrar

MEDICAL CERTIFICATION

20. Date of death March 24 1940, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from —, 19—, to —, 19—, and that I last saw him alive on —, 19—.

Immediate cause of death	Durstion
Coronary occlusion	
Sudden death	
Due to Previous illness	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. Hodgson M.D. (M. D. or other)
Address Lonaconing Md. Date signed March 26 1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 8 1940
REAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02616

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Rural near Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Locust Grove

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Locust Grove
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Thomas Dunn

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8 (b) Name of husband or wife Salina Alderton

8(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1854

8. AGE:

Years	Months	Days	If less than one day
86	1	9	hrs. min.

8. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Carpenter, Retired

11. Industry or business

FATHER 12. Name John Dunn

13. Birthplace W. Va.

MOTHER 14. Maiden name Ann Tusser

15. Birthplace Unknown

16. Informant Miss Nettie Dunn

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

18. Funeral director Louis Stein, Inc.

Address Cumberland Md.

19. Mar 21 1940, Jos. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1940, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1940, to March 18 1940, and that I last saw him alive on March 17 1940.

Immediate cause of death	DURATION
Cardiac Paralysis	
Due to Cerebral apoplexy	5 Days
or Hemiplegia	5 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D.
M. D. or other

Address 67 N. Centre St. Date signed 3-18-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

02617

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48 b)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 571 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 10 Market St
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alberta Richards Earsom

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Robert Earsom

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 3, 1874

8. AGE: Years: 65 Months: 8 Days: 5 If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own home

FATHER
12. Name: Meshach Richards
13. Birthplace: Frederick Co., Md.

MOTHER
14. Maiden name: Mary Valentine
15. Birthplace: Cumberland, Md

16. Informant: Mrs Leona Barnhart
Address: Martinsburg, W. Va.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Mar 11, 1940 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md

18. Funeral director: Jacob Hofer
Address: 130 Baltimore Ave.

19. Mar. 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

F. Wilson

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1940, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1936, to March 8 1940, and that I last saw her alive on March 8 1940.

Immediate cause of death: Carcinomatosis

Due to: Carcinoma uterus

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operation: Biopsy. Adeno-carcinoma
Of autopsy:

DURATION: 4 yrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. M. Wilson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 3-9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

02618

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 604 Montgomery Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 604 Montgomery Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jasper G. Enlow

3. (b) Social Security Number: 705-07-6776

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Barbara Lowdermilk
6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): January 26, 1877

8. AGE: Years	Months	Days	If less than one day
63	1	15	hrs. min.

9. Birthplace: Oakland, Garrett, Maryland
(Town, county, and state)

10. Usual occupation: Engineer, locomotive, retired
11. Industry or business: B. & O. Railroad

FATHER
12. Name: David T. Enlow
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lavena Wilkins
15. Birthplace: Pennsylvania

16. Informant: Mrs. Erma Moore
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 15, 1940 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 15, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

Dr. Durrett

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 12, 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 15, 1940, to Mar. 12, 1940, and that I last saw h— alive on Mar. 2, 1940.

Immediate cause of death: Coronary Thrombose (Dead on arrival) — DURATION: Sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clay E. Durrett M. D. or other
Address: Cumberland, Md. Date signed: Mar. 13, 1940.

RECEIVED
APR 2 1940
BUREAU V. M.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (92d)

Reg. Dist. No. 4

02619

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Bedford St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Ennis

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/1884

8. AGE: Years 56 Months 0 Days 16 If less than one day hr. min.

9. Birthplace Burkettsville Md
(Town, county, and state)

10. Usual occupation Jeweler

11. Industry or business Fixing Clocks

FATHER
12. Name William Ennis
13. Birthplace Burckettsville Md

MOTHER
14. Maiden Name Annie Fink
15. Birthplace Burckettsville Md

16 (a) Informant Mr. Nichel
(b) Address Waynesboro Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 21/40 (month) (day) (year)
(c) Cemetery or crematory Burckettsville Md
Location Burckettsville Md

18 (a) Funeral director Wm H. Kight
(b) Address Cumberland Md

19 (a) Mar. 19, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. Date of death March 18 1940, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1940, to Mch 18 1940, and that I last saw him alive on Mch 18 1940.

Immediate cause of death Chronic Endocarditis — Duration

Due to

Due to

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D. or other

Address 122 So Centre Date signed 3/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

02620

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 408 Cedar Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 408 Cedar Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Nettie Frances Farris

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: James A. Farris
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 3, 1879

8. AGE:

Years	Months	Days	If less than one day
60	5	3	hrs. min.

9. Birthplace: Great Cacapon, W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: John Savanger
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Ganoe
15. Birthplace: West Virginia

18. Informant: Lloyd R. Farris
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8 1940 (month) (day) (year)
Cemetery or crematory: Cacapon Cemetery
Location: Great Cacapon, W. Va.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Mar. 7 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 6, 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 1940, to Mar. 6, 1940, and that I last saw her alive on Mar. 5, 1940

Immediate cause of death: Chronic myocarditis
Due to: generalized Arteriosclerosis
Due to: Uraemia

DURATION: 1937 / 2/20/40

Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clay E. Farris
Address: Cumberland, Md. M. D. or other
Date signed: Mar. 6, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

02621

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 336 Front St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bernard Lorraine Fazenbaker

3. (b) Social Security Number: [redacted] 215-14-6352

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 22, 1921

8. AGE: Years: 18 | Months: 9 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Fairm Rock Garrett, Md.
(Town, county, and state)

10. Usual occupation: N.Y.A. Work

11. Industry or business: Pub public library

FATHER
12. Name: Jonas Fazenbaker
13. Birthplace: Pa Germany Garrett Co. Md

MOTHER
14. Maiden name: Flossie Michael
15. Birthplace: Fairm Rock Garrett Co. Md.

16. Informant: Mrs. Flossie Fazenbaker
Address: 336 Front St. Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1940 (month) (day) (year)

Cemetery or crematory: Shidler

Location: Westernport Md.

18. Funeral director: D. D. Boal

Address: Barton, Md.

19. Apr. 2 1940 (Date rec'd by registrar) J. Fazenbaker M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1940, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1939, to March 31 1940, and that I last saw him alive on March 31 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 Day
Due to: Hypertension	1 year
Due to: and Chronic Nephritis	3 years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul R. Weldon, M.D.
M. D. or other

Address: Piedmont, W. Va. Date signed: 4-2-40

RECEIVED
APR 4 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02622

1. PLACE OF DEATH (83-a)

County Allegany Registration Dist. No. 2

Village or City Flintstone R.F.D. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Frank Pierce Fletcher

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca E. Fletcher

6. DATE OF BIRTH (month, day, and year) Jan. 18, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own farm

10. Date deceased last worked at this occupation (month and year) Sept. 1936

11. Total time (years) spent in this occupation Quite Life

12. BIRTHPLACE (city or town) Clearville (State or country) Pennsylvania

FATHER

13. NAME Alexander Fletcher

14. BIRTHPLACE (city or town) (State or country) Pennsylvania

MOTHER

15. MAIDEN NAME Elizabeth Smith

16. BIRTHPLACE (city or town) (State or country) Pennsylvania

17. INFORMANT William Fletcher (Address) Cumberland Md.

18. BURIAL, CREMATION, OR REMOVAL Piney Plains Cemetery Date Apr. 2, 1940

19. UNDERTAKER Jacob Hafer (Address) Lonaconing Md.

20. FILED Apr 2, 1940 D. Bennett Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 31 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1940, to Mar. 31, 1940

I last saw him alive on Mar. 30, 1940; death is said to have occurred on the date stated above, at 4 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Mar. 29, 1940

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. A. Walsh M. D.

(Address) Little Orleans, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

02623

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 31 Ridgeway Terrace

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 31 Ridgeway Terrace (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: August Frost

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: WIDOWED ~~Married~~

6 (b) Name of husband or wife: Augusta Lechskwoi

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 1, 1855

8. AGE: Years: 84 Months: 3 Days: 15 If less than one day ____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Carpenter, retired

11. Industry or business

FATHER: 12. Name: Charles Frost

13. Birthplace: Germany

MOTHER: 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. George Weber

Address: 31 Ridgeway Terrace, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19, 1940 (month) (day) (year)

Cemetery or crematory: St. Luke Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Mar. 18 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

Dr. Eliason

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1940, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1938, to March 16 1940, and that I last saw him alive on March 16 1940.

Immediate cause of death: Chr.

	DURATION
Chronic nephritis	1930
Chronic Cystitis	1933
Due to Chronic Hypertrophied Prostate	1930
Due to Arterio Sclerosis	1930

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. W. Eliason MD M. D. or other

Address: 126 Union St. Cumberland Md Date signed: 3/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02624

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 484 Baltimore Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lois Louise Jean Gannon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Mar 4 1940

8. AGE: Years: Newborn | Months: | Days: 1 | If less than one day: ——— hrs. ——— min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER
12. Name John Rowe Gannon
13. Birthplace Nashville Tenn.

MOTHER
14. Maiden name Gladys Coletta Price
15. Birthplace Cumberland Md.

16. Informant Frank Gannon
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 6 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc
Address Cumberland Md

19. Mar. 6 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr Charles Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 4 1940, to Mar 5 1940, and that I last saw her alive on Mar 5 1940.

Immediate cause of death	DURATION
Probably intracranial birth injury	3-4-40
Due to Intracranial hemorrhage toxemia	10-20-39
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur T. Jones M.D.
M. D. or other
Address 407 N. Liberty St. Date signed 3-6-40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (143-7)

WITHIN CORPORATE LIMITS

D. J. Grahame 02625 9

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 49 Broadway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Slothen Jacob Grahame

3. (b) Social Security Number: 215-03-5845

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: Jennie Grahame
6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Feby 9 - 1904

8. AGE: Years: 36 Months: 1 Days: 23 If less than one day: hrs. min.

9. Birthplace: Frostburg Allegany Md (Town, county and state)
10. Usual occupation: Book keeper
11. Industry or business: Transport Co
FATHER 12. Name: John Grahame
13. Birthplace: Garrett Co Md
MOTHER 14. Maiden name: Grace Jacobs
15. Birthplace: Morgantown W Va
16. Informant: Geo. Grahame
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Frostburg Md
18. Funeral director: J. J. Hamat
Address: Frostburg Md
19. April 2nd 1940 (Date rec'd by registrar) Mrs. A. R. Walker (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: about March 31st., 1940, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---19---, to ---19---, and that I last saw h---alive on ---19---.

	DURATION
Immediate cause of death: Inhalation illuminating gas.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 3/31/40
Where did injury occur? Frostburg (City or town) Allegany (County) Maryland. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: illuminating gas Injured at work? no

23. SIGNATURE: Thomas H. Bowen M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 4/1/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(97)

02626

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Barton, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Barton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rachael Caroline Murphy Poland-Harper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William Harper

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29, 1859

8. AGE: Years	Months	Days	If less than one day
80 ~~Years~~	6	29	hrs. min.

9. Birthplace Lonaconing, Allegany, Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER 12. Name John Murphy

13. Birthplace Midland, Md.

MOTHER 14. Maiden name Margaret Mc Graham

15. Birthplace Little Washington, Pa.

16. Informant Mrs. George Williams

Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1940 (month) (day) (year)

Cemetery or crematory Old Coney

Location Lonaconing, Md.

18. Funeral director D. L. Beal

Address Barton, Md.

19. March 29 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~January~~ March 28 1940, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death

Arteriosclerosis

Due to No Physician in attendance from history of case would

Due to attribute death to the above

Cause and infirmities of

Other conditions old age

(Include pregnancy within 3 months of death)

DURATION

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. A. Boucher M. D. or other

Address Barton, Md. Date signed Mar 29

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02627

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Green St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Green St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Warren Karr

Gen. 220-10-2700

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Katherine Karr

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 24, 1874

8. AGE: Years 65 Months 7 Days 15 If less than one day ____ hrs. ____ min.

9. Birthplace Fairmont, Marion - W. Va (Town, county, and state)

10. Usual occupation Foreman.

11. Industry or business W. P. A.

FATHER 12. Name Raleigh Karr.

13. Birthplace Fairmont W. Va

MOTHER 14. Maiden name Mary Griffith

15. Birthplace Fairmont W. Va

16. Informant Katherine Karr.

Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 11, 1940 (month) (day) (year)

Cemetery or crematory Bloom

Location Westernport, Md.

18. Funeral director D. S. Boyle

Address Westernport, Md.

19. Mar 11 1940 A. Bayne Baker M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9, 1940, at 4:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1940, to March 9 1940, and that I last saw h im alive on March 8 1940

Immediate cause of death	DURATION
Typhoid Fever	9 Days
Due to	
Due to	
Other conditions Diabetes Mellitus	1 Year

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul A. Wilson, M.D. M. D. or other

Address Piedmont, W. Va. Date signed 3-9-40

RECEIVED
APR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-a)

CERTIFICATE OF DEATH

02628.

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 522 Greene St.
Stay in hospital or inst. (yrs., or mos., or days): 7 days.
Stay in this community (yrs., or mos., or days): 74 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 522 Greene St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mary Elizabeth Harris

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. F. Harris

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 28 1865

8. AGE: Years: 74 Months: 4 Days: 9 If less than one day: 10 hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Hamilton
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Henry Hamilton Brother
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 11 '40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. Mar. 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8th. 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8th 1940, to March 8th 1940 and that I last saw her alive on March 8th 1940

Immediate cause of death: Carcinoma of the Left kidney. — DURATION: Dec. 39 to March 40

Due to: unknown

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None

Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: J. J. Langton M.D. M. D. or other
Address: 54 N. Mechanic Date signed 3-9-40

RECEIVED
MAR 19 1940
BUREAU A. K.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02629

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Allegany Hosp.

Stay in hospital or inst. (yrs., or mos. or days) 17 days

Stay in this community (yrs., or mos., or days) 9 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Crecap Park - Route #5

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Luther Hedrick

3. (b) Social Security Number 214-07-3031

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife: Rosa B. Shirley

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.): April 21, 1884

8. AGE: Years 55 Months 11 Days 3 If less than one day ____ hrs. ____ min.

9. Birthplace: Upper Tract, W. Va. (Town, county, and state)

10. Usual occupation: Helper on truck, Engineering Dept.

11. Industry or business: Celanese Corp. of America

FATHER 12. Name: Charles Hedrick

13. Birthplace: Upper Tract, W. Va.

MOTHER 14. Maiden name: Amanda Hedrick

15. Birthplace: Upper Tract, W. Va.

16. Informant: Mrs. Walter M. Hedrick

Address: Route #5, Crecap Park, Cumberland, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 26, 1940 (month) (day) (year)

Cemetery or crematory: Hedrick Cem.

Location: Upper Tract, W. Va.

18. Funeral director: L. F. Mott

Address: Davis, W. Va.

19. Mar 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1940, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1940, to March 24, 1940, and that I last saw him alive on March 24, 1940.

	DURATION
Immediate cause of death: Cerebral Apoplexy	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE L. M. Hearlson M.D. M. D. or other

Address 122 So. Centre St. Date signed 3-25-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

02630

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 536 Greene Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 536 Greene Street
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margaret A. Hoblitzell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband or wife: Charles M. Hoblitzell
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1859

8. AGE: Years	Months	Days	If less than one day
80	10	26	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: James Farrell
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Reynolds
15. Birthplace: Unknown

16. Informant: Mrs. Richard Bender
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9 1940 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Mar. 8, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

Dr. Zimmerman

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-40 19 to 3-7-40 19, and that I last saw h alive on 3-2-40 19

Immediate cause of death: Apoplexy — DURATION: 3 mos.

Due to: arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. C. Zimmerman M. D. or other
Address: Cumberland, Md. Date signed: 3-7-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ma)

02631

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 da.

Stay in this community (yrs., or mos., or days) 1 mo 3 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 229 Bedford St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Robert Lee Hollen

3. (b) Social Security Number —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

B (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 3 1940

8. AGE: Years | Months 1 | Days 3 | If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Allegany Co Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Edgar Hollen
13. Birthplace Keyser W. Va.

MOTHER
14. Maiden name Mary J. Fleckenstein
15. Birthplace Cumberland Md

16. Informant Edgar Hollen
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 7, '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Mar. 7, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6, 1940, at 8:15 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3, 1940, to Mar. 6, 1940, and that I last saw him alive on Mar. 5, 1940.

Immediate cause of death: Fermentative Diarrhea — DURATION 2/27/40

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other

Address Cumberland, Md Date signed 3/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

02632

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND, County ALLEGANY
City or town CUMBERLAND, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 91 HENDERSON AVE.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
HUDSON, BABY GIRL (PREMATURE)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 6, 1940

8. AGE: Years NEW BORN | Months | Days | If less than one day 25 hrs. min.

9. Birthplace MEMORIAL HOSP, CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Albin Lee Hudson
13. Birthplace Nelson, Virginia

MOTHER 14. Maiden name Sally Mae Buchanan
15. Birthplace Buffalo, Virginia

16. Informant Memorial Hosp.
Address Cumberland, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Mar. 6, 1940 (month) (day) (year)

Cemetery or crematory Memorial Hosp.
Location Cumberland

18. Funeral director Same
Address

19. Mar. 12, 1940 J. P. Franklin, M. D.
(Date received by Registrar) BROOKE REYNOLDS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6, 1940 at 5;00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 6 1940, to Mar 6 1940, and that I last saw h[illegible] alive on Mar 6/40 19

Immediate cause of death Prematurity — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Knight Reynolds M D
M. D. or other
Address City Date signed Mar 12/40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02633

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 739 Washington St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 8 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Fayette
City or town Connellsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 508 S. Pittsburgh St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Miss Ella Augusta Hyatt

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1853

8. AGE: Years	Months	Days	If less than one day
86	8	1	hrs. min.

9. Birthplace Binghamton - New York (Town, county, and state)
10. Usual occupation Retired School Teacher
11. Industry or business School

FATHER
12. Name Hyatt
13. Birthplace Unknown

MOTHER
14. Maiden name Emma P. Bullock
15. Birthplace England

16. Informant Mrs. J. Hall Speer
Address 739 Washington St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 31, 1940 (month) (day) (year)
Cemetery or crematory Hill Grove Cemetery
Location Connellsville, Penna.

18. Funeral director Jacob Hafer
Address Cumberland Md.

19. Mar. 31, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1940, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-29- 1940, to 3-31- 1940, and that I last saw her alive on 3-30- 1940

Immediate cause of death	DURATION
Arteria Sclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings: None
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Cate of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jas. X. Williams M. D. or other
Address Cumberland Date signed 3/31/40.

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10c)

CERTIFICATE OF DEATH

02634

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 172 Wineow Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 172 Wineow Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Eston Johnson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (c) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): About 1898

8. AGE:

Years	Months	Days	If less than one day
About 42			hrs. min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Johnson
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Jane Myres
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27, 1940 (month) (day) (year)
Cemetery or crematory: Sumner Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 1940, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1940, to one visit, and that I last saw h[illegible] alive on March 9, 1940.

	DURATION
Immediate cause of death: Acute Parenchymatous Nephritis	14 Days
Due to: Thrombosis	14 Days
Due to: Dyspnea	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work? —

23. SIGNATURE: George C. Holloman M. D.
M. D. or other
Address: 145 - Hanover St. Date signed: 3-27-40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-a

02635

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Gilmore
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Gilmore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Jane A. Johnson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John E. Johnson
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 5 1855

8. AGE:

Years	Months	Days	If less than one day
84	6	26	____ hrs. ____ min.

9. Birthplace: Vale Summit, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
FATHER 12. Name: William Pennent
13. Birthplace: England
MOTHER 14. Maiden name: Hannah Elliott
15. Birthplace: England
16. Informant: Mrs. Hannah Gundle
Address: Gilmore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3 1940 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing Md.
19. April 3 1940 (Date rec'd by registrar) Dr. E. Dorsey (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1940, at 8 3/4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1940, to March 31 1940, and that I last saw h— alive on March 31 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ____ Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing Md. Date signed Apr. 2 '40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

02636

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 522 Washington St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 46 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 522 Washington Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Emmett Lee Jones Jr.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Annie R. Ford

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): May 27, 1865

8. AGE: Years	Months	Days	If less than one day
74	10	4	____ hrs. ____ min.

9. Birthplace: Florence, Alabama (Town, county, and state)

10. Usual occupation: Medical Doctor

11. Industry or business: Private

FATHER 12. Name: Albert H. Jones

FATHER 13. Birthplace: Alabama

MOTHER 14. Maiden name: Rebecca Boddie

MOTHER 15. Birthplace: Alabama

16. Informant: Dr. Emmett Lee Jones, Jr.

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. April 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1940, at 10:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1937, to Mar. 31 1940, and that I last saw him alive on March 31 1940

Immediate cause of death: Mitral regurgitation and Chronic Myocarditis — DURATION: 31 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: injured at work?

23. SIGNATURE: Emmett L. Jones Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: Mar 31, 1940

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 02637

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: St. Mary's Terrace

Stay in hospital or inst. (yrs., or mos., or days): ✓

Stay in this community (yrs., or mos., or days): 74 yrs. 1 mo. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: ✓ (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Margaret O'Toole Keating

3. (b) Social Security Number: ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thos. P. Keating

6(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb 5, 1866

8. AGE: Years: 74 Months: 1 Days: 26 If less than one day: ___ hrs. ___ min.

9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER

12. Name: Charles O'Toole

13. Birthplace: Ireland

MOTHER

14. Maiden name: Bridget O'Mara

15. Birthplace: Ireland

16. Informant: Miss Margaret Keating

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3, 1940 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. April 3 1940 (Date rec'd by registrar) E. Don Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 31 1940, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 24 1940, to Mch 31 1940, and that I last saw her alive on March 30 1940.

Immediate cause of death: Coronary arterial occlusion

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing Date signed: Apr. 2 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 7 HRS.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County Garrett
City or town OAKLAND, MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
KELLER, BABY GIRL

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 10, 1940

8. AGE: Years	Months	Days	If less than one day
			7 hrs. min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name KELLER, PAUL
13. Birthplace MD.

MOTHER
14. Maiden name EGGERS, MARY
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL,
Address CUMBERLAND, MD.

17. Removal Date thereof Mar. 14. 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Peter's Catholic Cem
Location Oakland, Md.
18. Funeral director Emory Bolden
Address Oakland, Md.

19. Mar. 14, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. REYNOLDS

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/40 19 , at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 10/40 19 , to Mar 10 1940, and that I last saw h alive on Mar 10/40 19 .

Immediate cause of death Cong. Atelectasis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dwight Reynolds MD
M. D. or other
Address City. Date signed Mar 11/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

02639

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 519 Memorial ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 5 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Memorial ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Jennie Olive Kitzmiller

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, ~~married~~, widowed, ~~or divorced~~ John P. Kitzmiller

6 (b) Name of husband or wife " " "

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1865

8. AGE: Years 74 Months 6 Days 10 If less than one day ____ hr. ____ min.

9. Birthplace McKeesport Pa
(Town, county, and state)

10. Usual occupation House duty

11. Industry or business Own House

FATHER
12. Name Luther Collier
13. Birthplace McKeesport Pa

MOTHER
14. Maiden Name Julianne Nethken
15. Birthplace Falk Garden W.Va

16 (a) Informant Miss Lucretia Kitzmiller
(b) Address 519 Memorial ave City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1940 (month) (day) (year)
(c) Cemetery or crematory Queens Point Cemetery
Location Keyser W.Va

18 (a) Funeral director William H. Kight
(b) Address Cumberland Md

19 (a) April 1, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Mch 29th 1940, at 9 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 20 1940, to Mch 29 1940 and that I last saw him alive on Mch 28 1940.

Immediate cause of death Influenzal Pneumonia

Due to Influenza

Due to

Other conditions Chronic Arterio Sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration: 10 days; 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Dwees M.D.
M. D. or other

Address Cumberland Md Date signed 3-29-40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

CERTIFICATE OF DEATH

02640

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 7 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 615 YALE STREET (If rural, give location)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. MARY KLAVUHN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife PETER KLAVUHN

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) JANUARY 27, 1892

8. AGE: Years	Months	Days	If less than one day
48	1	28	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name DANIEL WOLFE

13. Birthplace MARYLAND

MOTHER 14. Maiden name Unknown

15. Birthplace MARYLAND

16. Informant Mr. Peter M. Klavuhn

Address 615 Vale St. City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 19, 1940 (month) (day) (year)

Cemetery or crematory Trinity Luthern Cem.

Location Cumberland, Md.

16. Funeral director J.C. Wolford

Address Cumberland, Md.

19. Mar. 15, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 11:00 A.M.

20. DATE OF DEATH MARCH 16 19 40 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 19 40 to March 16 19 40 and that I last saw her alive on March 15 19 40

Immediate cause of death: Hypertrophy Cardiac Decompensation. DURATION ?

Due to Heart Block 24 hr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr Page Hodges M.D. M. D. or other

Address Cumberland, Md. Date signed 3/16/40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (152)

CERTIFICATE OF DEATH

02641

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 10½ hrs.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Fifth St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Earl Knippenberg

3. (b) Social Security Number: 214-05-6112

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Nancy Huff Knippenberg
6(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): ? May 2, 1911

8. AGE: Years	Months	Days	If less than one day
28	10	3	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Truck driver
11. Industry or business: Brick & tile - Pen-Mar

FATHER
12. Name: Steve Knippenberg
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Leona Irons
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7, 1940. (month) (day) (year)
Cemetery or crematory: Davis Memorial Cemetery
Location: Along Oldtown road

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Mar. 6, 1940 (Date rec'd by registrar) J. L. Franklin, M.A. Registrar

DR. GROVE

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5th, 1940, at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4 1940, to Mar. 5, 1940, and that I last saw h-e alive on Mar 5, 1940.

Immediate cause of death	DURATION
Fractured skull	3/4/40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 3/4/40
Where did injury occur? (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): farm
Means of injury: Falling from tractor on head Injured at work? yes.

23. SIGNATURE: D. B. Grove M.D.
M. D. or other
Address: Medical Bldg. Date signed 3/5/40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-d)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

02642

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Vale Summit (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henry Kohl

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19, 1860

8. AGE: Years 79 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Vale Summit, Allegany, Md. (Town, county, and state)

10. Usual occupation Cobbler

11. Industry or business Shoe Repair - Retail

FATHER 12. Name George Kohl

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Kohl

15. Birthplace Germany

16 (a) Informant Andrew Seifarth

(b) Address 89 Mt. Pleasant St - Fbg. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18, 1940 (month) (day) (year)

(c) Cemetery or crematory Allegany

Location Frostburg

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md.

19 (a) Mar. 18, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 3-15- 1940, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13- 1940, to 3-15- 1940 and that I last saw him alive on 3-15- 1940

Immediate cause of death Arteriosclerosis

Due to Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. F. Williams M. D. ~~or other~~

Address Cumberland Date signed 3-18-40

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-C)

CERTIFICATE OF DEATH

02643

Reg. Dist. No. 4 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County ~~ALLEGANY~~ ~~CUMBERLAND, MARYLAND~~
City or town
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
~~MEMORIAL HOSPITAL~~
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 119 ELDER, STREET
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MRS. ROSE E. LACEY

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife LEE H. LACEY
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~SEPT. 29~~ October 9, 1874

8. AGE: Years	Months	Days	If less than one day
65	4	25	hrs. min.

9. Birthplace MARYLAND (town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home

FATHER
12. Name Peter J. Stump
13. Birthplace Maryland

MOTHER
14. Maiden name Chloe McCully
15. Birthplace Maryland

16. Informant LEE H. LACEY
Address ~~119 ELDER ST., CUMBERLAND, MD.~~

17. Burial Date thereof March 7, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Mar. 7, 1940 J. P. Franklin, M.A.
(Date rec'd by registrar) Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION 12;55 A.M.

20. DATE OF DEATH MARCH 5, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1939, to Mar 5 1940
and that I last saw h-r alive on Mar 4 19 40

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M.D.
M. D. or other
Address 34 Va. Ave Date signed 3/6/40
Cumberland Md

RECEIVED
MAR 19 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02644

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Barton Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 17 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Anna Mae Langham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B (b) Name of husband or wife

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): May 26 1922

8. AGE: Years: 17 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Barton, Allegany, Md. (Town, county, and state)

10. Usual occupation: School girl

11. Industry or business

FATHER 12. Name: Herbert Langham

13. Birthplace: Barton, Md.

MOTHER 14. Maiden name: Faze Best

15. Birthplace: Lonaconing Md.

16. Informant: Herbert Langham

Address: Barton, Md.

17. Burial (Burial, cremation, or removal). Which?) Date thereof: March 14 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Frostburg, Md.

18. Funeral director: D. D. Brady

Address: Barton, Md.

19. March 14 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11th 1940, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1940, to March 11 1940, and that I last saw h[er] alive on March 11 1940.

Immediate cause of death: Influenza

DURATION: 2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed

RECEIVED
APR 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

02645

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

(92d)

County Allegany — Registration Dist. No. 4

Village or City Cumberland, Md. — No. 117 Paca St — St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME

Mrs. Susan Largent — If U. S. Veteran, specify WAR ...

(a) Residence: No. 117 Paca St — St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Largent

6. DATE OF BIRTH (month, day, and year): Oct. 27, 1868

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	3	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Pennsylvania

FATHER

13. NAME: Abraham Thomas

14. BIRTHPLACE (city or town) (State or country): England

MOTHER

15. MAIDEN NAME: Elizabeth Doubt

16. BIRTHPLACE (city or town) (State or country): Pennsylvania

17. INFORMANT: Mrs. Addie Sowers

(Address) 117 Paca St.

18. BURIAL, CREMATION, OR REMOVAL

Place Lovely, W. Va. Date Mar. 12, 1940

19. UNDERTAKER: Virgil L. Lemperseur

(Address) Cumberland, Md.

20. FILED Mar. 12, 1940 J. P. Franklin, M.A. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: March 9, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 4 5, 1940, to March 9, 1940

that I last saw her alive on March 9, 1940, that death is said to have occurred on the date stated above, at 11:20 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Endocarditis	

Other Contributary Causes of importance:

Chronic Myocarditis	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) R. H. Weathers M.D., M. D.

(Address) 174 So. Centre St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED APR 8 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

02646

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: W. M. Railroad, near Welton's Tunnel
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 245 Offutt Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Andrew Jackson Lewis

3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
B (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 13, 1930

8. AGE: Years 9 Months 7 Days 13 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)
10. Usual occupation Schoolboy
11. Industry or business John Humbird School
FATHER 12. Name James T. G. Lewis
13. Birthplace Cumberland, Maryland
MOTHER 14. Maiden name Ruth May Howdersheldt
15. Birthplace Moorefield, W. Va.
16. Informant James T. G. Lewis
Address Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1940 (month) (day) (year)
Cemetery or crematory Harper's Ferry Cem.
Location Harper's Ferry, W. Va.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland
19. Mar. 29, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th., 1940, at about 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

Immediate cause of death Fracture base of skull
Killed instantly
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 3/26/40
Where did injury occur? Near Cumberland, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Fall from a cliff, near Cumberland, Md.
Means of injury Fall Injured at work? no

23. SIGNATURE Lorenzo H. Corson, M.D. M. D. or other
Address Cumberland, Md. Date signed 3/28/40

Deputy Medical Examiner - Allegany Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46b)

CERTIFICATE OF DEATH

02647

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Pinto, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pa County Somerset.

City or town Springs. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Wilbert Eugene Livengood.

3. (b) Social Security Number 175-16-8978

4. Sex Male

5. Color or race white

6. (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Barbara Otto.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1873

8. AGE: Years 67 Months 1 Days 28 If less than one day hrs. min.

9. Birthplace Somerset Co, Pa.
(Town, county, and state)

10. Usual occupation Well Driller.

11. Industry or business Prospecting for Coal water etc.

FATHER
12. Name Wm C. Livengood.
13. Birthplace Meyersdale, Pa.

MOTHER
14. Maiden name Wagner.
15. Birthplace Somerset Co, Pa.

16. Informant Michael Livengood.
Address Pinto, Md

17. Burial Date thereof Mar 13, 1940.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springs Mennonite

Location Springs, Pa.

18. Funeral director Jacob Hafer.
Address Cumberland, Md.

19. 3/13 1940 [signature]
(Date rec'd by registrar) Registrar

Dr J Bowen.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1940, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1940, to March 11 1940, and that I last saw him alive on March 9 1940.

Immediate cause of death Carcinoma of Stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. C. Bowen MD
M. D. or other

Address Cumberland Md Date signed 4-12-40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

02648

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Catherine Logsdon

3. (b) Social Security Number

4. Sex F
5. Color or race Wh
6. (a) Single, married, widowed, or divorced Single
B (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 4 1869.
8. AGE: Years 70 Months 4 Days 19. If less than one day hrs. min.
9. Birthplace Mt Savage Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Own Home
FATHER 12. Name John L Logsdon
13. Birthplace Ohio
MOTHER 14. Maiden name Anna Mary Carolin
15. Birthplace Mt Savage Md.
16. Informant Richard Logsdon
Address Mt Savage Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 26 1940 (month) (day) (year)
Cemetery or crematory St Patricks Cemetery
Location Mt Savage Md
18. Funeral director Jones & Stringer
Address Cumberland Md.
19. Mar 25 1940 (Date rec'd by registrar) H. Bostetter M D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23rd 1940, at 9:40 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1940, to Mar 23 1940, and that I last saw her alive on Mar 22 1940.

	DURATION
Immediate cause of death Acute Dilatation of Heart	
Due to Chronic Endocarditis Mitral Regurgitation	2 yrs
Due to	
Other conditions Influenza	3 wks

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Bostetter M. D.
M. D. or Other
Address Mt Savage Md Date signed 3/25/40

RECEIVED
APR 2 1918
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02649

Reg. Dist. No. 16.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage - Sunny Side
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Infant Mac Millan.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	W	Sing le

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9 - 1940

8. AGE: Years | Months | Days | If less than one day 2 hrs. min.

9. Birthplace Mt Savage
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Mary

13. Birthplace

MOTHER 14. Maiden name Mary Mac Millan.

15. Birthplace Lonaconing Md

16. Informant Thomas Linn

Address Mt Savage Md

17. Burial Date thereof Mar 10 - 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sunny side.

Location

18. Funeral director Thomas Linn.

Address Mt Savage Md.

19. Mar 9 1940 H. J. Bostetter M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1940, at 3. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 9 1940, to Mar 9 1940, and that I last saw h- alive on Mar 9 1940.

Immediate cause of death	DURATION
Premature Birth	
6 1/2 mo —	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M. D.
M. D. or other

Address Mt Savage Md Date signed 3/9/40.

RECEIVED
APR 2 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106G)

02650

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1016 Gay Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 1016 Gay Street (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Males.

3. (b) Social Security Number None

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 29, 1877

8. AGE: Years 62 Months 2 Days 29 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Retired — cook

11. Industry or business restaurant

FATHER 12. Name Thomas Males

13. Birthplace Maryland

MOTHER 14. Maiden name Carthenne Carey

15. Birthplace Maryland

16. Informant Lawrence Males

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1940 (month) (day) (year)

Cemetery or crematory Sumner Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19 Mar. 30 19 40 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1940, at 1255 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1940, to March 27 1940 and that I last saw him alive on March 27, 1940.

Immediate cause of death Bronchiectasis — DURATION 3 yrs

Due to Exposure Colds

Due to

Other conditions Bronchial Asthma — 2 yrs

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE George C. Holbrand M.D. M. D. or other

Address 145 Hanover St. Date signed 3-29-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-B)

02651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 26 Laing Avenue, East
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 26 Laing Avenue, East
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Thomas Maxwell

3. (b) Social Security Number 105-10-0720

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8 (b) Name of husband or wife: Martha M. Hall
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1869

8. AGE: Years	Months	Days	If less than one day
70	8	23	hrs. min.

9. Birthplace: Grafton, West Virginia (Town, county, and state)
10. Usual occupation: Retired Conductor
11. Industry or business: B. & O. Railroad

FATHER
12. Name: Thomas Maxwell
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Charlotte Shingelton
15. Birthplace: West Virginia

18. Informant: Mrs. Robert Brown
Address: 26 E Laing Ave, Cumberland, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 27, 1940 (month) (day) (year)
Cemetery or crematory: Harmony, West Virginia
Location: near Grafton, W.Va.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar 26, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 27, 1940, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 25, 1940, to Mar 27, 1940, and that I last saw him alive on Mar 25, 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	6 hr
Due to	
Due to	
Other conditions: Hypertension + Chr. Nephritis	many years

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland, Md. Date signed 3-25-40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 9

02652

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 131 center
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 131 center (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Nellie Grimes McAteer
3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward McAteer
6(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Mar 5 - 1884
8. AGE: Years 56 Months 0 Days 14 If less than one day hrs. min.
9. Birthplace: Queen - Alleg - Md. (Town, county, and state)
10. Usual occupation: house wife
11. Industry or business
FATHER 12. Name: John Grimes
13. Birthplace: Ireland
MOTHER 14. Maiden name: Bridget Dugan
15. Birthplace: Ireland
16. Informant: Wm Grimes
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 21 - 1940 (month) (day) (year)
Cemetery or crematory: St. Michaels,
Location: Frostburg Md.
18. Funeral director: J. J. Dwirst,
Address: Frostburg Md.
19. Mar. 20 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1940, at 2 45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/18/40 19 , to 3/19/40 19 , and that I last saw her alive on 3/19/40 19
Immediate cause of death: Cardiac Failure & Pulmonary Edema
Due to
Due to
Other conditions: Diabetes Mellitus, Pulmonary Tuberculosis (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John Kilday. M.D. M. D. or other
Address: 56 W. Main St. Frostburg Md. Date signed 3/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 2 1949
BUREAU V.S.

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02653

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Bowmans Addition near Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Bowmans Addition, Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(if rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Alice Jane McCoy

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wm. McCoy

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1861.

8. AGE: Years: 78 Months: 6 Days: 1 If less than one day ____ hrs. ____ min.

9. Birthplace: Elbinsville, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Phillip Hymes
13. Birthplace: Penna.

MOTHER
14. Maiden name: Elizabeth Shirley
15. Birthplace: Penna.

16. Informant: Mr. John McCoy

Address: Bowmans Addt. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 4, 1940 (month) (day) (year)

Cemetery or crematory: McCoy Cem.

Location: Near Balti. Pike Polish Mountain

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. Mar. 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st 1940, at 1:P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938, to Mar. 1, 1940, and that I last saw her alive on Feb. 26, 1940.

Immediate cause of death: Chronic Myocarditis

DURATION: 2 yrs.

Due to ✓

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓

Of autopsy ✓

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Geo. Paulman M. D. or other

Address: Cumberland Md. Date signed: 3/2/40

RECEIVED
APR 6 1940
BUREAU F. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

02654

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Struck by car on Bedford Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 148 Frederick Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Bernard McDermott

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1936

8. AGE: Years	Months	Days	If less than one day
3	5	14	hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: --

11. Industry or business

FATHER — 12. Name: George Francis McDermott

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Doris Jean Mitchell

15. Birthplace: Maryland

16. Informant: George F. McDermott

Address: 148 Frederick St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4, 1940 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Mar. 4, 1940 (Date rec'd by registrar) J. P. Franklin, MA Registrar

MEDICAL CERTIFICATION 2p.

20. DATE OF DEATH: March 1st., 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw h alive on 19.

	OURATION
Immediate cause of death: Fracture, base of skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: accident Date of 3-1-1940

Where did injury occur? Cumberland, (City or town) Allegany, (County) Md. (State)

Injured at home, farm, industry, public place (where?): Street

Means of injury: struck by automobile Injured at work? no

23. SIGNATURE: Samuel H. Bowen, M. D. (M. D. or other)

Address: Cumberland, Maryland. Date signed 3-2-40

Deputy Medical Examiner - Allegany

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

CERTIFICATE OF DEATH

02655

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Potomac Park, R.D. #5

(Or rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Infant McKenzie (Stillborn)

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	W	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15 - 1940

8. AGE: Years: STILL BORN | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Robert McKenzie

13. Birthplace: Meyersdale - Pa.

MOTHER — 14. Maiden name: Edna McKenzie

15. Birthplace: Powhattan Pa.

16. Informant: Robert McKenzie

Address: Cumberland, R.D. #5

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 15, 1940 (month) (day) (year)

Cemetery or crematory: Meyersdale, Penna.

Location:

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Mar. 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1940, at 12:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: STILL BORN — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Barrow M.D. M. D. or other

Address: 122 Bedford St Date signed: 3-15-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

02656

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 Da.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County Bedford
City or town Fairhope, Pa. Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mr. George Merkle

3. (b) Social Security Number 205-09-3448

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hulda Richardson
6(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1896

8. AGE:

Years	Months	Days	If less than one day
44	0	10	hrs. min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual occupation Labor
11. Industry or business
FATHER 12. Name Harry J. Merkle
13. Birthplace Penna.
MOTHER 14. Maiden name Lottie Suter
15. Birthplace Penna.
16. Informant Victor Merkle
Address Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 10, 1940 (month) (day) (year)
Cemetery or crematory Trinity Lutheran
Location Cumberland, R.D.
18. Funeral director Harvey H. Zeigler
Address Hyndman Pa.
19. Mar. 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th. 1940, at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 5 1940, to Mar 7 1940, and that I last saw h[illegible] alive on mar 7 1940.

	DURATION
Immediate cause of death Acute Nephritis	1 week.
Due to	
Due to	
Other conditions Chronic Myocardiosis	1937
Bronchial Asthma	1929.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A. Sopper M.D. M. D. or other
Address Hyndman Pa. Date signed 3/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

02657

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 729 Bedford St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 729 Bedford St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Francis Montgomery

3. (b) Social Security Number: 214-10-5569

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Ida Jenkins

6(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): March 28 - 1886

8. AGE: Years: 54 Months: — Days: 1 If less than one day: hrs. min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Electrical Appliances

FATHER: 12. Name: Joseph Montgomery

13. Birthplace: Penna

MOTHER: 14. Maiden name: Laura Sunderlan

15. Birthplace: Penna

16. Informant: Mrs Ida Montgomery

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 1-40 (month) (day) (year)

Cemetery or crematory: Greenmont

Location: Cumberland, Md

18. Funeral director: V. L. Lemperen

Address: Cumberland Md.

19. April 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-29-1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1940, to 3-29-1940, and that I last saw him alive on 3-29-1940.

Immediate cause of death: ~~Chronic Nephritis~~ ~~Hypertension~~ DURATION ?

Due to: Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. ~~or other~~

Address: Cumberland Date signed: 4-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

02658

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Westernport Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Reeves Clinic
Stay in hospital or inst. (yrs., or mos., or days) 16 days
Stay in this community (yrs., or mos., or days) "

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Shirley Moore

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 3, 1938

8. AGE: Years 1 | Months 9 | Days 19 | If less than one day — hrs. — min.

9. Birthplace Lonaconing Allegany Co. Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Joseph D. Moore
13. Birthplace Maryland

MOTHER 14. Maiden name Ruth Bittinger
15. Birthplace Maryland

16. Informant Joseph D. Moore
Address Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 23 1940 (month) (day) (year)
Cemetery or crematory Old Caney
Location Lonaconing, Md.

18. Funeral director M. Eichhorn
Address Lonaconing, Md.

19. Mar. 22 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1940, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 6, 1940, to March 22 1940, and that I last saw her alive on March 22 1940.

Immediate cause of death	DURATION
Uremic Poisoning	4 days
Due to Acute Nephritis	10 days
Due to 2° burn over lower back and legs - (from boiling water)	3-6-40
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 3-6-40
Where did injury occur? near Lonaconing, Md (Rome)
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Setting tub hot water Injured at work? —

23. SIGNATURE Raymond W Reeves, M.D.
M. D. or other
Address Westernport Md Date signed 3-22-40

RECEIVED
APR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

02659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 12 Decatur St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 57 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 12 Decatur St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emma Eshelman Morgart

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife John C. Morgart.
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1862

8. AGE:

Years	Months	Days	If less than one day
78	2	18	____ hrs. ____ min.

9. Birthplace Rays Hill, Fulton Co., Pa. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business At Home.
FATHER 12. Name John Eshelman
13. Birthplace West Providence Township Pa.
MOTHER 14. Maiden name Priscella Nycum
15. Birthplace Monroe Township - Pa.
16. Informant Ralph C. Morgart
Address 402 Fayette St., Cumb. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 2, 1940 (month) (day) (year)
Cemetery or crematory Rose Hill Mausoleum
Location Cumberland Md.
18. Funeral director Jacob Hafer.
Address Cumberland Md.
19 April 2 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. J. W. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30-1940, at 10 10 M P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-4-1936, to 3-30-1940 and that I last saw her alive on 3-28-1940

Immediate cause of death a Toxic Nephritis — DURATION ?
c Hypertension ?
Due to b Toxic Myocarditis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 4-1-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-C

02660

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 44 N. Mechanic Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Michael Eugene Murphy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1940

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Paul Patrick Murphy
13. Birthplace Westernport, Maryland

MOTHER
14. Maiden name Mary Elona Landon
15. Birthplace Bloomington, Maryland

16. Informant Paul Murphy
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 29. 1940 (month) (day) (year)

Cemetery or crematory Thulos Cemetery

Location Westernport, Md.

18. Funeral director David S Boal

Address Westernport Md.

19. Mar. 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28 1940, at 10:35 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 26 1940, to Mar. 28 1940, and that I last saw him alive on Mar 28 1940.

Immediate cause of death	DURATION
Ruptured Kidney - Convulsions	1 hrs.
Due to Breech Extraction	
Due to Maternal valvular heart disease & decompensation.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur T. Jones M. D.
M. D. or other

Address 40 N. Liberty St. Date signed 3-28-40

RECEIVED
APR 8 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-d

02661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Route 3.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Route 3
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John David Nazelrod

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Kigiah Nazelrod

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug 2 1854

8. AGE: Years 86 | Months 6 | Days 2 | If less than one day ____ hrs. ____ min.

9. Birthplace ~~Cider~~ Criders Va
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Fredrick Nazelrod
13. Birthplace: West Va

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Virginia

16. Informant: Jacob A. Nazelrod
Address: Route 3 Cumberland Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 7 1940 (month) (day) (year)

Cemetery or crematory: Perry Cemetery

Location: Perry West Va

18. Funeral director: V. L. Lempewer

Address: Cumberland Md

19. Mar 6 1940 (Date rec'd by registrar) Jos. P. Franklin, Mo. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1940, at 1:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to March 4 1940, and that I last saw him alive on March 1 1940.

Immediate cause of death: Acute Dilatation of Heart

Due to: Chronic Myocarditis and Endocarditis

Due to

Other conditions: Senility

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Cate of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address 41 [illegible] St Cumberland Va

Date signed March 6 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

02662

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 12 Uhl St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Gerald Nickel

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1922

8. AGE: Years: 17 | Months: 10 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Frostburg Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Cyril Nickel
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Mary Wiebbecht
15. Birthplace: Frostburg, Md.

16. Informant: Cyril Nickel
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20-1940 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. Mar. 19 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 17 1940, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 13 1940, to Mar 17 1940, and that I last saw him alive on Mar 17 1940

Immediate cause of death	DURATION
Acute Cardiac Dilatation	1 Day
Due to	
Due to Acute Bronchitis	4 Days
Other conditions: Progressive Muscular Dystrophy (Include pregnancy within 3 months of death)	10 yrs

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. H. Lane M.D.
M. D. or other
Address: Frostburg Md. Date signed: Mar 19 40

RECEIVED
APR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-P)

02663

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: Bedford St
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland (If outside city or town limits, write RURAL, NEAR and give town) Ward No.
Street No.: (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Michael O'Rourke

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 13, 1885
8. AGE: Years: 54 Months: 3 Days: 8 If less than one day: hrs. min.
9. Birthplace: Midland, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine

FATHER
12. Name: Patrick O'Rourke
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Ann Cavanaugh
15. Birthplace: Ireland

16. Informant: Hugh J. O'Rourke
Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 25, 1940 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Maryland

18. Funeral director: M. Eichhorn
Address: Lonaconing, Maryland

19. Mar. 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21st 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to March 21 1940, and that I last saw h— alive on March 21 1940.

Immediate cause of death: Cancer of Tonsils (Bilateral)
Due to: Secondary Metastasis To Lungs.
Due to:
Other conditions:

DURATION: 6 mos.

(Include pregnancy within 3 months of death)
Major findings:
Of operations: Biopsy Report Carcinoma.
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. C. Bowen M.D.
M. D. or other
Address: Cumberland Md. Date signed 3-23-40

RECEIVED
APR 8 1940
BUREAU V. S.

02664

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: National (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 42 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: National Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Rachael Anita Bobo Owens

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Curtis Owens

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): April 4, 1855

8. AGE: Years 84 | Months 11 | Days — | If less than one day ___ hrs. ___ min.

9. Birthplace: Moorefield W. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: ~~H~~ Bobo
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Browning
15. Birthplace: W. Va.

16. Informant: Mrs. Olive Robertson

Address: Paris Ave, Akron Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 6, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. March 5 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1940, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 1940, to March 4 1940, and that I last saw her alive on March 4 1940.

Immediate cause of death: Pneumonia (Broncho)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M. D. M. D. or other

Address: Midland, Md Date signed: 4-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

02665

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (469)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 212 Thomas Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 212 Thomas Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ida Mae Palmer

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Walter E. Palmer

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 21, 1875

8. AGE: Years 64 Months 4 Days 8 If less than one day hrs. min.

9. Birthplace Cumberland Allegany Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name August Hensel
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Smith
15. Birthplace Unknown

16. Informant Walter E. Palmer
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Mar. 30 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1940, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1939, to Mar. 29 1940, and that I last saw her alive on Mar. 29 1940.

Immediate cause of death Carcinoma Head of Pancreas — DURATION ?

Due to —

Due to —

Other conditions Cirrhosis of Liver — ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma Pancreas & Cirrhosis of Liver

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. J. Lanich M.D.
M. D. or other

Address Cumberland Md. Date signed 3/30 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 33

Reg. Dist. No. 4

02666

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Lonaconing (If outside city or town limits, write RURAL and give town)
(d) Street No. Dudley (If rural give location)
(e) If foreign born, how long in U. S./A.? years

3 (a) FULL NAME Walter Dent Patton

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 1939

8. AGE: Years | Months: 5 | Days: 3 | If less than one day: hr. min.

9. Birthplace Keyser, Mineral Co, W. Va. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William Patton
13. Birthplace Lonaconing, Md.

MOTHER 14. Maiden Name Geraldine W. White
15. Birthplace Newburg, W. Va.

16 (a) Informant Mrs. Wm. Patton
(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28 (month) (day) (year)
(c) Cemetery or crematory Allegany Cemetery
Location Fairfield, Md.

18 (a) Funeral director M. Erichson
(b) Address Lonaconing Md.

19 (a) Mar. 27, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death March 26, 1940 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4, 1940 to March 26, 1940, and that I last saw him alive on March 26, 1940

Immediate cause of death	Duration
Intestinal Influenza	4 days
Due to	
Massive infantile Eczema	
Due to covering entire body	3 Months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. P. Franklin M. D. (M. D. or other)
Address 41 Greene St. Date signed 3/26/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

02667

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 4 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town BARTON Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Main
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MASON PERKINS, MR.

3. (b) Social Security Number 216-07-2367

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELIZABETH HUNSINGER

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) AUGUST 2 - 1877

8. AGE:

Years	Months	Days	If less than one day
62	7.	27	hrs. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Paper Mill

FATHER
12. Name MERRITT PERKINS (DECEASED)
13. Birthplace VIRGINIA

MOTHER
14. Maiden name CARRIE PERKINS (DECEASED)
15. Birthplace VIRGINIA

16. Informant Mrs. Elizabeth Perkins
Address Barton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 1. 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow Md.

18. Funeral director David S. Boal
Address Barton Md.

19. April 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 5:03 PM

20. DATE OF DEATH MARCH 29 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1940, to March 29 1940, and that I last saw him alive on March 29 1940.

Immediate cause of death Pulmonary embolism

Due to following operation for acute pancreatitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Chr. Hepatitis & Chr. Cholecystitis - acute Cholecystitis
Of autopsy

DURATION 7 days

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. Wilson M.D. M. D. or other

Address Cumbd Md Date signed 3-30-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02668

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 117 South Centre St.
Stay in hospital or insl. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 117 South Centre Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME
Frances Pord Ora Poling #1

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9, 1940

8. AGE: Years	Months	Days	If less than one day
		7	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Walter Poling
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Geatz
15. Birthplace: West Virginia

16. Informant: Walter Poling
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Mar. 18, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1940, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1940, to March 16 1940, and that I last saw h ER alive on March 15, 1940.

Immediate cause of death	DURATION
Cardiac weakness	
Due to Premature birth	
7 months in utero.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. W. Deming M. D.
M. D. or other
Address: 67 N. Centre St. Date signed: 9-16/40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02669

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 117 South Centre St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 117 South Centre Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Mary Delores Emma Poling #2 ~~[illegible]~~

3. (b) Social Security Number
None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 9, 1940

8. AGE: Years | Months | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Walter Poling
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Geatz
15. Birthplace: West Virginia

16. Informant: Walter Poling
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 18 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1940, at 2:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1940, to March 14 1940, and that I last saw her alive on March 13 1940.

Immediate cause of death: Cardiac weakness

Due to: Premature birth 7 months in utero

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. V. Deming M.D. M. D. or other
Address: 67 N. Center St. Date signed: 3-14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

02670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany.

City or town: Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 wks.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany.

City or town: Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 203 Valley St.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Albert Reed Jr.

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Infant.

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Mar. 2, 1936

8. AGE: Years: 4 Months: 0 Days: 17 If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: John A. Reed
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Hogamier
15. Birthplace: Maryland.

16. Informant: John A. Reed
Address: 203 Valley St. Cumberland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 22, 1940.
(month) (day) (year)

Cemetery or crematory: S.S. Peter Paul Cem.

Location: Cumberland, Md.

18. Funeral director: J. C. Wolford.

Address: Cumberland, Md.

19. Mar. 21 1940. Jos. P. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 19, 1940, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1940, to March 19 1940 and that I last saw him alive on March 19 1940.

Immediate cause of death: Neoplasm of left kidney with generalized metastases

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: Neoplasm left kidney with metastases

DURATION: 1 mo 19 days

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: James T. Johnson Jr.
M. D. or other

Address: Cumberland Md. Date signed: 3-21-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

02671

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegheny

City or town: Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 730 Bedford St.,

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 730 Bedford St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs. Mary Catherine Reid

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late James Reid

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec 23 1848

8. AGE: Years 91 Months 4 Days 5 If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John Heefrey

13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Schmidt

15. Birthplace: Germany

16. Informant: Mrs. Richard McCardell

Address: 730 Bedford St, City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 30 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland

18. Funeral director: Virgil L Lempereur

Address: 202 Green St Cumberland

19. Mar. 30, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/28/40 19 ____, at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/28/40 19 ____, to 3/28/40 19 ____, and that I last saw her alive on 3/28/40 19 ____.

Immediate cause of death: Chronic Myocarditis General debility and old age

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Richard J. Williams MD M. D. or other

Address: 34 Va. Ave. Date signed: 3/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 2 1940
BUREAU V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142-B)

CERTIFICATE OF DEATH

026729

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County Allegany
City or town Frostburg Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 102 Bowery St.
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 102 Bowery St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Leona Mary "Carter" Richardson

3. (b) Social Security Number 214-07-5394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married.

8 (b) Name of husband or wife George E. Richardson
6(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) May 24 1913

8. AGE:

Years	Months	Days	If less than one day
26	9	20	hrs. min.

9. Birthplace Mt. Savage, Allegany, Md (Town, county, and state)
10. Usual occupation Textile Worker.
11. Industry or business Celanese Corporation
FATHER 12. Name Owen T. Carter.
13. Birthplace Mt. Savage
MOTHER 14. Maiden name Clara V. Caldwell
15. Birthplace Corriganville Md.
16. Informant Rance Richardson
Address 102 Bowery St Frostburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 16, 1940 (month) (day) (year)
Cemetery or crematory St. Michaels
Location Frostburg Md.
18. Funeral director Jacob Hafer
Address Frostburg Md
19. 3-15-1940 (Date rec'd by registrar) Miss. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1940, at 5:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 10 1940, to Mar 14 1940, and that I last saw h alive on Mar 14 1940.

Immediate cause of death	DURATION
Ruptured Ectopic Pregnancy	about 6 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. M. McLane Jr. M.D.
M. D. or other
Address Frostburg Md Date signed Mar 15 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

9:30 AM

RECEIVED
APR 2 1940
BUREAU V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

02673

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Westernport, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days) ~~5 days~~ 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. 214 Wood St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maud Wilson Robertson

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George W. Robertson

6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 28, 1879

8. AGE: Years: 60 Months: 10 Days: 10 If less than one day: ____ hrs. ____ min.

9. Birthplace: Westernport, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Jacob E. Wilson

13. Birthplace: Fort River, N. Va.

MOTHER

14. Maiden name: Mary E. Jones

15. Birthplace: Mayfield, N. Va.

16. Informant: Mr. George W. Robertson Sr.

Address: 214 Wood St. Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 11, 1940 (month) (day) (year)

Cemetery or crematory: Shivs Cemetery

Location: Westernport, Md.

18. Funeral director: D. D. Boals

Address: Barton, Md.

19. Mar. 11 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 8, 1940, at 7:50 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 4 1940, to Mar 8 1940, and that I last saw h[illegible] alive on Mar 6 1940.

Immediate cause of death: Cerebral Thrombosis — DURATION: 4 days

Due to: Chronic Myocarditis — DURATION: 7

Due to: —

Other conditions: Carcinoma of Liver

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: L. A. Reeves M.D. M. D. or other

Address: Westernport Md. Date signed 3-8-40

RECEIVED
APR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02674

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 29 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County SOMERSET
City or town WEST SALISBURY Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME EMMA RODAMER, MRS.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOHN RODAMER
6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) AUGUST 18, 1877

8. AGE: Years	Months	Days	If less than one day
62	6	18	hrs. min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name THOMAS, ABRAHAM
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name MARY JONES
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 9, 1940 (month) (day) (year)
Cemetery or crematory I. O. O. F. Cem.
Location Salisbury, Penna.

18. Funeral director Stanley M. Thomas
Address Salisbury Penna

19. Mar 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W.F. WILLIAMS

MEDICAL CERTIFICATION 7:05

20. DATE OF DEATH MARCH 6th, 1940, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 1940, to March 6 1940 and that I last saw h ev alive on March 5 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	
Chronic Nephritis, ?	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jno. F. Williams M. D. or other
Address Cumberland Date signed 3/9/40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

02675

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 32 Pennsylvania Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 32 Pennsylvania Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3.(a) FULL NAME Maggie Belle Russler (Russler)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: ####
Samuel H. Russler 6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): Aug. 23, 1874

8. AGE: Years	Months	Days	If less than one day
65	7	1	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home
FATHER 12. Name: James H. C. Dailey
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Elizabeth E. Gardner
15. Birthplace: W. Va.
16. Informant: Mrs. H. L. Fisher
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Mar. 26, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1940, at 8:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1935, to Mch 24 1940, and that I last saw her alive on March 5 1940.

Immediate cause of death	DURATION
Dead on arrival.	
Due to Chronic Hyperthyroidism	
Due to Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. B. Matthews M. D. M. D. or other
Address 172 So Centre St Date signed 3-25-40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (1860) Reg. Dist. No. 9

CERTIFICATE OF DEATH

02676

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos 2 days
(e) Length of stay in this community (yrs., mos., or days) 50 years

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 54 Ormand St (If rural give location)
(e) If foreign born, how long in U. S. A.? 50 years years

3 (a) FULL NAME Sophia Sapiro

3 (b) If veteran, name war ~ | 3 (c) Social Security No. ~

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Sapiro Deceased | 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 84 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Saul Sapiro
(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10, 1940. (month) (day) (year)
(c) Cemetery or crematory East View Cemetery
Location Cumberland, Maryland

18 (a) Funeral director Jacob Kahn
(b) Address Cumberland, Maryland

19 (a) Mar 10 40 (Date rec'd by registrar) (b) Wm. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Dste of death Mar 8 1940, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1939, to Mar 8 1940, and that I last saw him alive on Mar 7 1940.

Immediate csuse of desth	Duration
Chronic Myocarditis	Several years
Due to	
Due to	
Other conditions Fracture of Left Femur (Include pregnancy within 3 months of death)	Sept 6 1939

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which desth should be chsrged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 6 1939
(c) Where did injury occur? Frostburg (City or town) Alleg (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Her Home (Specify type of place) While at work? no
(e) Means of injury Fell in bedroom

23. Signature W. M. Lane Jr M.D. M. D. or other
Address Frostburg Md Date signed Mar 8 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 2 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

02677

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Mexico Farms, R.F.D. #4
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Settle

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

B(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1940

8. AGE: Years Months Days If less than one day Stillborn hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Ashby Settle
13. Birthplace Maryland

MOTHER
14. Maiden name Rosella Long
15. Birthplace Maryland

16. Informant Mr Ashby Settle

Address R.F.D. #4, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1940 (month) (day) (year)

Cemetery or crematory Long Cem

Location Mexico Farms, Mt. Cumberland

18. Funeral director Louis Stein, Inc

Address Cumberland, Md.

19. Mar. 31, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1940, at 5:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death

Due to Stillborn

Due to Dramatism

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Lowe M. D. or other

Address Cumberland Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

02678

1. PLACE OF DEATH:

(a) County Allegany County

(b) City or town Frostburg, Maryland
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miner's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in this community (yrs., mos., or days) 83 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(d) Street No. 46 Borden Road.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Duncan Eugene Shaffer.

3 (b) If veteran, name war —

3 (c) Social Security No. None

4. Sex Male

5. Color or race White

6 (a) ~~Single, married,~~ widowed, ~~or divorced.~~ widowed

6 (b) Name of husband or wife Lucy Kimsloe.

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 23, 1856

8. **AGE:** Years 83 | Months 8 | Days 2 | If less than one day _____ hr. _____ min.

9. Birthplace Frostburg, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Grocery & Dry Goods Store

FATHER

12. Name Henry Bramwell Shaffer

13. Birthplace Shellsburg, Pa.

MOTHER

14. Maiden Name Louisa Kemmerer

15. Birthplace Shellsburg, Pa.

16 (a) Informant Henry Shaffer.

(b) Address Grant St., Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27, 1940 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg, Maryland.

19 (a) Mar 27-40 (Date rec'd by registrar) (b) mrs. A. R. Baker Registrar

MEDICAL CERTIFICATION

20. Date of death Mar 22 1940, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1940, to Mar 25 1940, and that I last saw him alive on Mar 24 1940.

Immediate cause of death	Duration
Carcinoma of Stomach	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** W. M. Lane M.D.
M. D. or other

Address Frostburg Md Date signed Mar 26 1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 2[illegible] 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

02679

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days): ELEVEN DAYS

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: WEST VIRGINIA County: MINERAL

City or town: FORT ASHBY R.F.D. #2 Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MRS. LEONA SHOBE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife: CLYDE H. SHOBE

6(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): APRIL 30, 1897

8. AGE:

Years	Months	Days	If less than one day
42	10	28	hrs. min.

9. Birthplace: Grant County, W. Va. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: At Home

FATHER
12. Name: GEORGE JUDY
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: ALICE HEDRICK
15. Birthplace: WEST VIRGINIA

16. Informant: Clyde H. Shobe (husband)
Address: Fort Ashby W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 30, 1940 (month) (day) (year)

Cemetery or crematory: Petersburg Cem

Location: Petersburg, W. Va

18. Funeral director: Earle Bush
Address: Petersburg, W. Va.

19. Mar. 30, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 28 1940, at 9:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/17 1940, to 3/28 1940, and that I last saw her alive on 3/28 1940.

Immediate cause of death: Acute Toxic Nephritis

Due to: Coma second day

Due to: 2 Stage Op. for Cancer Rectum

Other conditions (Include pregnancy within 8 months of death)

Major findings: Large Obstructing Tumor Brain

Of operations

Of autopsy

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. H. Hawkins M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-B)

CERTIFICATE OF DEATH

02680

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Inn, Baltimore Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Allegany Inn, Baltimore Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles Henry Sizer

3. (b) Social Security Number: 332-10-5556

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret Deming
6(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1902

8. AGE: Years	Months	Days	If less than one day
37	6	0	hrs. min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)
10. Usual occupation: Fireman Tie Plant; W. Va.
11. Industry or business: Bookkeeper

FATHER
12. Name: Lynn Sizer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Fannie Snyder
15. Birthplace: Maryland

16. Informant: Mrs. Margaret D. Sizer
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 26 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about March 25th., 1940, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19__, to ____, 19__, and that I last saw h__ alive on ____, 19__.

Immediate cause of death	DURATION
Poisoning by Potassium Cyanide	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: March 25th 1940
Where did injury occur? Cumberland, (City or town) Allegany, (County) Md. (State)
Injured at home, farm, industry, public place (where?): Hotel
Means of injury: Poisoning Injured at work? no

23. SIGNATURE: Russell H. Larson M. D.
M. D. or other
Address: Cumberland, Maryland Date signed: 3/25/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 28 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

02681

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 88 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County Allegany

City or town FLINTSTONE Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. AMOS R. SMITH

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ANNIE THOMPSON

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 2, 1860

8. AGE:

Years	Months	Days	If less than one day
79	10	10	hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business

FATHER

12. Name DAVID SMITH

13. Birthplace PENNSYLVANIA

MOTHER

14. Maiden name ELIZABETH MAKINS

15. Birthplace PENNSYLVANIA

16. Informant Mrs. Mattie Cosgrove

Address 516 Avondale ave. Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 14, 1940 (month) (day) (year)

Cemetery or crematory OddFellowes Cem.

Location Near Flintstone, Md.

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Mar. 14, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 9:44 A.M

20. DATE OF DEATH MARCH 12 19 40, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 19 39, to 3-12- 19 40, and that I last saw him alive on 3-17- 19 40

Immediate cause of death Cerebral Hemorrhage

DURATION 2 hours.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 3/12/40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

02682

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 227 Emily St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edmund Blair Smith

3. (b) Social Security Number 212-18-1428

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Nettie Bowden

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 3 1860

8. AGE: Years 79 | Months 6 | Days 8 | If less than one day ____ hrs. ____ min.

9. Birthplace Greenstone, Allegany, Md (Town, county, and state)

10. Usual occupation Salesman

(Industry or business) Cumberland Wholesale Produce Co.

FATHER 12. Name Isaac Smith

13. Birthplace Allegany County, Md.

MOTHER 14. Maiden name Nancy Hilsen

15. Birthplace Allegany Co. Md.

16. Informant Mary E. Smith

Address 227 Emily St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 13, 1940 (month) (day) (year)

Cemetery or crematory Pleasant Grove

Location Baltimore Pike Cumberland

18. Funeral director Jacob Hafer.

Address Frostburg, Md.

19 Mar. 15, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

Dr. Bowen -

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1940, at 9:46 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1940, to March 11 1940, and that I last saw h alive on March 10 1940

	DURATION
Immediate cause of death Apoplexy	9 days.
Due to Arterio sclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Bowen M.D. M. D. or other

Address Cumberland Md Date signed 4-12-40

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

02683

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 825 Oldtown Rd.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 825 Oldtown Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Elizabeth Snyder

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jessie B. Snyder

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1852

8. AGE: Years 87 Months 9 Days 3 If less than one day hrs. min.

9. Birthplace Fulton County, Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name Jos. Powell
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Anna Mellott
15. Birthplace Pennsylvania

16. Informant Miss Anna M. Snyder
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 1940 (month) (day) (year)

Cemetery or crematory Tonoloway Baptist Cemetery

Location 2 mi. north of Hancock, Maryland

18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Mar. 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 11 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 8 1940, to March - 11 1940, and that I last saw h w alive on March - 9 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	1936
Due to Arteriosclerosis	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Eleason M.D. M. D. or other
Address 126 Union St. Cumberland Md. Date signed 3/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-B)

02684

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ~~16 H.~~ Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 28 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 16 Front St.,

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Jackson E Stattlemeyer

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1882

8. AGE: Years	Months	Days	If less than one day
58	0	8	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Restaurant Worker

11. Industry or business

FATHER 12. Name Jackson Stattlemeyer

13. Birthplace Md

MOTHER 14. Maiden name Mary —

15. Birthplace Md

16. Informant Emmett J. Stattlemeyer

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/40 (month) (day) (year)

Cemetery or crematory St Patrick's

Location Cumberland, Md.

18. Funeral director V. L. Lemperem

Address Cumberland, Md.

19. Mar. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1940, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1939 to Mar 2 1940

and that I last saw him alive on Mar 1 1940.

Immediate cause of death Cancer of bladder — DURATION 18 mos

Due to Cancer of prostate

Primary cancer of prostate. C.W.S.R.

Due to Duration: Eighteen months.

Other conditions Pyelonephritis — 6 mos.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Cancer of bladder & pyelonephritis

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Trwaski M.D. M. D. or other

Address Cumberland, Md Date signed 3/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-E)

Dr. Kilday 026859

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 10 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Maple Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Thomas

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1867

8. AGE: Years 72 | Months 11 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Mt. Savage, Md. (Town, county, and state)

10. Usual occupation: Retired miner

11. Industry or business: Coal mines

FATHER
12. Name: Wm. Thomas,
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Lewis
15. Birthplace: England

16. Informant: Wm. Thomas,

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Mar. 20th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1940, at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1940, to March 18 1940, and that I last saw h 1M alive on March 17 1940.

Immediate cause of death: Senility without mention of senile dementia. C.W.S.A.

Due to: Malnutrition

Due to: no further information

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John Kilday, M.D. M. D. or other

Address: 56 W. Main St. Frostburg, Md. Date signed: 3/19/40

RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

02686 4

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 217 Maple St WITHIN CORPORATE LIMITS

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 217 Maple St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rutherford B. Thomas

3. (b) Social Security Number 222-10-1062

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1887

8. AGE: Years	Months	Days	If less than one day
53	1	27	hrs. min.

9. Birthplace Frostburg Allegany Md (Town, county, and state)

10. Usual occupation ~~None~~ Laborer

11. Industry or business ~~Coal Industry~~ W.P.A

FATHER 12. Name Alfred Thomas

13. Birthplace England

MOTHER 14. Maiden name Rebecca Hayes

15. Birthplace Cresaptown, Md

16. Informant Mrs. Irene Horton

Address New Shaft - Frostburg Md.

17. Burial Date thereof Mar 17, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director Jacob Hafer

Address Frostburg. Md.

19. Mar. 11th 1940 Mrs. A. R. Walker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/40 19 20 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death Coronary Thrombosis — DURATION

Due to Never saw deceased before date of death. Was dead on my arrival there

Due to

Other conditions Valley Stained from family.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Kilday, M. D.

M. D. or other

Address 50 W. Main St. Frostburg Md. Date signed 3/11/40

RECEIVED
APR 2 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

02687

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 618 Frederick St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 618 Frederick St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Omer Thompson

3. (b) Social Security Number: 214-05-7701

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 4, 1891

8. AGE: Years: 48 Months: 6 Days: 4 If less than one day: hrs. min.

9. Birthplace: Frostburg Allegany Maryland (Town, county, and state)

10. Usual occupation: Bookkeeper

11. Industry or business: Garage, Thompson Motor Co.

FATHER
12. Name: James Thompson
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Elizabeth McCaughan
15. Birthplace: Frostburg, Md.

16. Informant: Gerard Thompson

Address: 624 1/2 Frederick St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 9, 1940 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Hofer

Address: 230 Baltimore Ave.

19. Mar. 9, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-7-1940, at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1938, to 3-7-1940 and that I last saw her alive on 3-6-1940.

Immediate cause of death: Carcinomatosis of abdominal viscera.

Due to: Glands & structures in left groin

Due to: apparently in the original site.

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations: None.

Of autopsy: None.

DURATION: 1 1/2 yrs.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. ~~or other~~

Address: Cumberland Date signed: 3-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02688

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 39 Mary Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 39 Mary Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William E. Tucker

3. (b) Social Security Number: 214-05-4228

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martha Best
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1882 ?

8. AGE: Years: about 58 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Keyser W. Va.
(Town, county, and state)

10. Usual occupation: Imperial Ice Cream Co.

11. Industry or business

FATHER
12. Name: Mason Tucker
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Virginia McKnemar
15. Birthplace: W. Va.

16. Informant: Mrs. Mae Hausman
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 7, 1940 (month) (day) (year)
Cemetery or crematory: Episcopal Cemetery
Location: Mt. Savage, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Mar. 7, 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1940 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1940, to March 5 1940, and that I last saw him alive on March 5 1940.

Immediate cause of death: Chronic Myocarditis — DURATION: 4 years
Due to: due to arteriosclerosis.
Due to:
Other conditions: Coronary Occlusion — 5 Weeks
(Include pregnancy within 3 months of death)
Major findings:
Dt operations:
Dt autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Cumberland Md Date signed: 3/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

02689

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 hours 35 minutes

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. R. D. #5 Cumberland (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Warner

3. (b) Social Security Number Infant

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1940

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 15 min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Robert Charles Warner

13. Birthplace Fingel, Md.

MOTHER 14. Maiden name Pauline Louise Kines

15. Birthplace Cumberland, Md.

16. Informant Robert C. Warner

Address R. D. 5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 16, 1940 (month) (day) (year)

Cemetery or crematory Greenville Cem.

Location Pocohantas Penna.

19. Funeral director Wolford J. C.

Address Cumberland, Md.

19. Mar. 15 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1940, at 12 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 - 1940, to March 14 1940, and that I last saw h alive on March 14 1940

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to	
Other conditions Premature rupture of Membranes	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. W. Zeiger M. D. or other

Address Cumberland Md. Date signed 3-19-40

RECEIVED
APR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

02690

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: 101 Penna Ave Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Cumberland,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: WEIMER, BABY BOY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1940

8. AGE: Years | Months | Days | If less than one day: Stillborn hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Charles Weimer
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Geraldine Spidell
15. Birthplace: Maryland

16. Informant: Chas E Weimer,
Address: 101 Pa ave.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 3-18-40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein & Sons

Address: Cumberland.

19. Mar. 19 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 18 1940, at 8 35 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Mar. 18 1940 to Mar 18 1940, and that I last saw him alive on Stillborn 19

Immediate cause of death	DURATION
Intrauterine Asphyxia	3-18-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nathan Jones M. D.
M. D. or other

Address: 402 N. Liberty St. Date signed 3-18-40

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02691

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Alleganey

City or town Barton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Isabella Missouri Wilt

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Isaac C. Wilt

6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1882

8. AGE: Years	Months	Days	If less than one day
57	11	27	hrs. min.

9. Birthplace Frostburg-Allegany- Md.

(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business House-hold

FATHER 12. Name John Cassidy

13. Birthplace not known

MOTHER 14. Maiden name Sarah Teter

15. Birthplace Frostburg, Md.

16. Informant Isaac C. Wilt

Address Franklin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 15, 1940 (month) (day) (year)

Cemetery or crematory Forest Glen

Location Green Sring, W.Va.

18. Funeral director D.S.Boal

Address Westernport, Md.

19. March 14 1940 (Date rec'd by registrar) S.A. Bruchon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12 1940, at 4300pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1940, to March 12 1940, and that I last saw her alive on March 12 1940.

Immediate cause of death	DURATION
Influenza	Mar 1-40
Due to acute myocarditis	3/10/40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide na Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry MD

M. D., or other

Address Piedmont W.Va. Date signed 3/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (463)

CERTIFICATE OF DEATH

02682

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County Allegany

City or town Zihlman Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Zihlman Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Joseph Winebrenner

3. (b) Social Security Number 219-03-9865

4. Sex	5. Color or race	6. (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie E. Duvall

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1868

8. AGE: Years 71 | Months 7 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace Eckhart Mines, Allegany, Md.
(Town, county, and state)

10. Usual occupation Brick Setter

11. Industry or business Fire Brick Plant.

FATHER 12. Name James Winebrenner

13. Birthplace Midland Md.

MOTHER 14. Maiden name Susan Jackson

15. Birthplace Eckhart, Md.

16. Informant Thos. Cunningham

Address Zihlman, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 30, 1940 (month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Eckhart Mines Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. Mar. 30 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1939 to Mar 28 1940 and that I last saw him alive on Mar 28 1940

Immediate cause of death Carcinoma of Stomach — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm McLane Jr. M.D. M. D. or other

Address Frostburg Md Date signed Mar 29 40

RECEIVED
APR 2 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02693

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland R.D. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Braddock Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harvey C. Wineland

3. (b) Social Security Number 220-10-0137

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Ada Burley 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1871

8. AGE:

Years	Months	Days	If less than one day
69	1	22	hrs. min.

9. Birthplace Fredericksburg, Penna. (Town, county, and state)

10. Usual occupation Coal Dealer

11. Industry or business

FATHER

12. Name Jacob L. Wineland

13. Birthplace Penna

MOTHER

14. Maiden name Elizabeth - - - - - ?

15. Birthplace Unknown

16. Informant Mrs Hazel Miller

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 7 1940 (month) (day) (year)

Cemetery or crematory Hyndsman Cemetery

Location Hyndsman, Pa.

18. Funeral director H. H. Zeigler

Address Hyndsman Pa.

19. Mar. 6 1940 (Date rec'd by registrar) J. F. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1940, at 3:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 1940, to March 3 1940, and that I last saw him alive on March 3, 1940.

Immediate cause of death Hemiplegia, right side — DURATION 6 dys

Due to Cerebral Hemorrhage

Duration: Three days Cur. R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson Jr. M. D. or other

Address Cumberland, Md. Date signed 3-9-40

RECEIVED
APR 8 1940
BUREAU V. S.